



ENVIRONMENTAL HEALTH PROJECT

LESSONS LEARNED

Advancing Environmental Health for Disease Prevention:
Past Experiences and Future Priorities

Urban Health

EHP and its predecessor projects have been addressing the needs of people living in marginalized urban settings for over 15 years. Beginning with water supply and sanitation in peri-urban settlements, activities have evolved to broader hygiene improvement and child health interventions for the urban poor who might live at the fringes of a city or in pockets of poverty in the middle of one. Most recently, EHP has worked to set these efforts within the broader context of urban health.

EHP's urban health portfolio has included two large programs and several smaller scale activities. The centerpiece of EHP's urban health programming is the USAID/India Urban Child Health and Nutrition Program, with slum-based neonatal health and hygiene improvement activities in Indore, Jamshedpur, Kolkata and Agra. Other key components are advocacy and technical assistance to the GOI in developing urban health strategies and increasing the knowledge base of urban child health information. The program is two years old and will continue to be funded by USAID/India beyond the end of EHP.

The second large urban health activity at EHP is the Asia Near East (ANE) Urban Health Initiative, funded by the Asia Near East Regional Bureau. Since 2001, EHP has carried out activities aimed at increasing our understanding of urban child health conditions throughout the region and has proposed program strategies that could be effective for USAID. The Initiative has included a desktop study of child health in slums of Asia and Near East, an on-the-ground health and hygiene improvement program in a slum in Cairo



Cairo Urban Slum Residents

(the Cairo Healthy Neighborhood Program) in partnership with the USAID/Egypt Mission and Making Cities Work (USAID/EGAT Urban Programs), and the sponsoring of an urban health workshop for all ANE Missions held in Agra, India, in February 2004. Key program lessons are emerging from the Cairo Healthy Neighborhood Program and from the India Urban Child Health Program.

EHP also conducted an urban health assessment for the USAID/Ghana Mission prior to its 5-year strategy development, which led to the inclusion of an urban focus in one of its key health programs. In addition, EHP participated in the final evaluation of the USAID-funded CARE/Madagascar Urban Environmental Health/Food Security Project.

Lessons

- ✓ **Key Lesson Learned:** Focusing child health interventions in urban settings is crucial. Evidence shows that the health status of children in urban poor settings is as bad and often worse than in rural areas. Urban poor children under-five suffer more and die more



often from diarrhea and acute respiratory infections than rural children.

- ✓ **Lesson 1:** For an urban health initiative to be sustainable, it is critical to identify and involve the universe of stakeholders in the activity at various times and in various ways. Stakeholders can be from the community, the local and national government, private sector, non-governmental sector, etc. This approach is essential to effective urban programs.

The principle of stakeholder involvement is part of EHP's approach to development work. It has been particularly effective when applied to urban program settings. In Egypt, the complexity of the governance structure for the target neighborhood was unraveled and the right people who have power to act were brought to the table. Stakeholder meetings have included elected parliament members as well as officials from the local and governorate (provincial) levels of government. Coupled with regular telephone communications and meeting minutes, decision makers at senior levels have become better informed about the problems and activities in the slum neighborhood.

In India, this process has led to the creation of partnerships and context-appropriate strategies, promotion of ownership, improved resource utilization from varied sources and elimination of duplication of efforts. In the Ghana urban health assessment, identifying stakeholders helped create an urban organogram of use to both the GOG and USAID in developing urban components to health programs.

- ✓ **Lesson 2:** There is very little good data on urban poor, at-risk populations. This impedes advocacy for governments and donor organizations to address the health needs of these populations and hinders the development of appropriate programs. We need to organize more and better urban data collection tools and strategies, including mapping of slums and bring evidence of need and conditions into the program planning and advocacy process.

As part of the ANE Urban Health Initiative, EHP conducted a desktop study on urban child health in the ANE region. The conclusion that

little useful data were available on the subject led EHP to address the problem of good available data on the urban poor through a number of activities. EHP has been working closely with EGAT/Urban Programs to improve both the indicators and the data collection process for sampling urban slum populations, leading to the development of a separate EH module specially adapted to urban settings. In addition, EHP/India had conducted a large baseline survey in the city of Indore and has reanalyzed DHS data for large urban agglomerations such as Mumbai according to a standard of living index. Findings are that infant and child mortality rates and malnutrition are worse in urban children than in rural ones.

In Egypt, the Cairo Healthy Neighborhood Program is finalizing a quantitative neighborhood environmental assessment and a water quality assessment to complement a qualitative situation analysis. Results of the data collection are shaping program approaches and influencing policymakers. The maps and data information generated by project activities have been in great demand by local officials and organizations. Information of this sort has not generally been available for local users.

- ✓ **Lesson 3:** USAID may not have adequate resources dedicated to urban health, but many other sources exist. They can be identified and leveraged through stakeholders meetings and advocacy events.

In India and Egypt, meetings with urban stakeholders where evidence-based, environmental and health conditions in urban slums were presented for discussion and action, previously unknown resources—financial, material and organizational—were brought to the attention of program implementers. In India, technical assistance to the stakeholders in proposal development led to formulation of plans for improving services and increasing coverage using newly identified resources.

- ✓ **Lesson 4:** Environmental factors and lack of services contribute significantly to health problems in poor urban settings. Lack of water and sanitation is top on the list. Any urban health effort

should consider an environmental health component, and the Hygiene Improvement Framework (access to hardware + hygiene promotion + enabling environment) is a useful program organizing tool. Health sector agencies can partner with municipal agencies, private providers and donor programs whose role it is to provide WSS services. Stakeholder meetings are good venues for this collaboration (see Lesson 1).

In the qualitative and quantitative surveys undertaken or reviewed by EHP, urban slum residents place problems with adequate drinking water and excreta disposal at the top of their complaints about inadequate services. The high incidence of hygiene related diseases corroborate this problem. In Indore, EHP is working with both the community and the municipal corporation to find slum-specific approaches to improving sanitation. EHP brought Indore officials on a study tour of Pune where the city has successfully addressed slum sanitation. The community is developing a plan for maintaining a rehabilitated toilet block. NGOs and CBOs are conducting hygiene behavior change promotion in slums. In the Cairo slum neighborhood, water and sanitation improvements are being supported through a grant from Making Cities Work, while complementary hygiene promotion is being carried out via adult literacy and community promoters using materials featuring urban hygiene themes. Combining hardware and software interventions leads to improved chances for health impact.

- ✓ **Lesson 5: Principles and processes of community participation and empowerment are as important if not more so when developing and carrying out health programs in urban slums as compared to working with rural communities. Lack of services and official neglect of urban slums stem largely from the urban poor not having a voice in requesting their due from the municipal and national structures governing them and often from official ignorance. A two-tiered approach to empowerment and change is often required, with activities at the level of the individual local community in conjunction with changes in policy at higher levels of government authority.**



Participatory Mapping in Indore Slum

The USAID/CARE Madagascar Urban Environmental Health Program put as much effort into a “community-driven development” process as in infrastructure development. The process involved helping neighborhoods form development committees who produced a Neighborhood Development Plan after careful analysis of problems of infrastructure, services availability and health conditions. These Development Plans are now being used by the Municipal Government of Antananarivo as the basis for improvements to the neighborhoods, legitimizing the grassroots work of the neighborhood residents.

In India, Participatory Community Inquiry on neonatal survival and birth practices led to development of a methodology for the community to shape the direction of the health program. Community ownership is being fostered through community-based organizations, who are the main implementers, with support from NGOs and municipal services. City-based program efforts and policy review and program development at state and national levels are going on simultaneously. Learnings from the slum-based program feed into the development of appropriate policies and large-scale programs.

In the Cairo Healthy Neighborhood Program, the emphasis on a two-tiered approach started with the kickoff community level and government/donor level stakeholders meetings. This led to the formation of a coordination committee that has met on and off during implementation in the community. Through this committee, the local government,

the Ministry of Health and Population, and the governorate responsible for the neighborhood have become very aware of issues related to service delivery in urban slums and have begun to address issues of policy obstacles.

- ✓ **Lesson 6:** There is a need for urban health programs to include the large number of private (formal and informal sector) health providers who are accessed by the urban poor. Urban health programs should seek ways to improve the quality of their services rather than exclude them.

Surveys of the urban poor show that a large proportion prefers to use private providers for health care because of accessibility, confidence and affordability factors. Most health programs, however, work with the public sector. In India, the Urban Child Health Program is partnering with formal sector providers who provide services at periodic health camps for women and children. Utilization of the private informal sector is still a challenge the program is hoping to address in the future.

In Cairo, the project has focused on efforts to formalize the government and private sector institutional relationships that relate to maintenance and operation of informal, private sewer networks. Discussions are underway to finalize a protocol between the community (through a local NGO), the local government unit and multiple private contractors, which clarifies the roles and responsibilities of the different parties. This will improve the capability of contractors to effectively install and maintain the sewage disposal infrastructure.

- ✓ **Lesson 7:** Available resources are rarely sufficient for tackling urban health problems in all their breadth and depth. Urban health programs must allocate resources to identify, map and prioritize the most vulnerable slums and urban poor populations. It doesn't take much money to improve conditions on a local level, but it does take time and adequate levels of support to ensure the sustainability of activities. Projects should be designed so that small amounts of money can be injected

regularly into local organizations to enable them to sustain their catalytic actions in the community. Often the problems are complex and require solutions that are not easy to diagnose or implement.

The USAID/India Urban Health Program realized early on that it could not cover the needs of the huge numbers of urban poor residing in Indian cities, even in select cities. As part of its initial situation analysis of Indore, over 500 slums were identified. It became clear that some form of prioritization was necessary. From this, a "Health Vulnerability Assessment" process was developed, using criteria such as "presence of NGO" and a ranking system for these criteria. This process led to the identification of about 70 highly vulnerable slums where program interventions have begun. The methodology is being applied and refined in more Indian cities.

In the Cairo Healthy Neighborhood Program, the initial decision to focus on a particular neighborhood was taken as a result of discussions with the Ministry of Health/Population and the USAID mission. As the project's environmental assessment activities commenced, the team faced questions of, "Why this site and not others?" This highlights the need to develop a similar vulnerability assessment tool for use in the Egyptian context.

Conclusion

Urban Health Programming is a relatively new field within EHP. We are continuing to learn as we move along with various program efforts. Developing urban health programs requires patience and participation. It takes time to understand the context, and to facilitate the development of a context-specific program. Early experience emphasizes the value of beginning programming efforts with an open mind, with no pre-designed program (as each urban center is unique with its own needs, resources, challenges and opportunities), only a broad objective and framework for partnership, assessing challenges and opportunities with stakeholders and seeking ideas. The initial experience has also

reinforced the belief that if stakeholders have adequate and good technical information they can develop a program responsive to the needs and conditions of most vulnerable urban poor populations. Such a consultative planning process is key to the effectiveness and sustainability of urban health programs.

Key Documents

Participatory Community Health Enquiry and Planning in Selected Urban Slums of Indore, Madhya Pradesh And A Field Guide for Community Facilitators of PCHEP. Activity Report 127

Cairo Healthy Neighborhood Program: Situation Analysis with Literature Review and Stakeholder Meetings, ANE Urban Health Initiative and USAID/Egypt/PHN. Activity Report 123

CARE Madagascar, Title II Final Evaluation Report of Findings. Joint Publication 9

Health of Children Living in Urban Slums in Asia and the Near East. Review of Existing Literature and Data. Activity Report 109

Ghana Urban Health Assessment. Activity Report 114